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	Atorvastatin 80 mg (N=38)	Placebo (N=38)	p Values
Age (years)	58,4±7,8	49,6±8,7	0,897
Male	31 (82%)	33 (86%)	0,529
Clinical history			
Diabetes	13 (34%)	11 (30%)	0,622
Hypertension	21 (55%)	16 (42%)	0,251
Hypercholesterolemia	13 (34%)	12 (32%)	0,807
Familial history	5 (13%)	7 (18%)	0,509
Smokers	20 (52%)	20 (52%)	1,000
LVEF (%)	44,3±10,9	48,1±10,3	0,977
Onset (hours)	6,5±2,7	6,4±2,6	0,879
Killip Classification			
Killip 1	30 (79%)	35 (92%)	0,103
Killip2	8 (21%)	3 (8%)	0,103
TIMI score	6,5±2,7	6,4±2,6	0,879
Renal insufficiency			
CCt (ml/min/m^2)	75,4±15,7	81,3±17,0	0,117
CCt ≤ 60 ml/min/m^2	6 (16%)	5 (13%)	0,744
Medications			
ACE-i/ARB	31 (82%)	25 (66%)	0,118
Beta-blockers	28 (73%)	28 (73%)	1,000
OAD	13 (34%)	11 (30%)	0,622

	Atorvastatin 80 mg (N=38)	Placebo (N=38)	p Values
Culprit lesion			
LAD	18 (47%)	14 (37%)	0,353
LCx	3 (8%)	3 (8%)	1,000
RCA	17 (45)	21(55%)	0,359
Multivessel Disease	21 (55%)	23 (60%)	0,642
Intracoronary thrombus	5 (13%)	3 (8%)	0,455
Intervention			
POBA	3 (8%)	5 (13%)	0,455
Stent	35 (92%)	33 (87%)	0,455
Stent type			
BMS	16 (42%)	20 (53%)	0,355
DES	19 (50%)	13 (34%)	0,355
TIMI-3 flow (n,%)	33 (87%)	35 (92%)	0,455
GP IIb/IIIa inhibitor	5 (13%)	3 (8%)	0,455

ICAM (Intercellular Adhesion Molecules) Values

	Atorvastatin 80 mg (N=38)	Placebo (N=38)	p Values
ICAM at 0 jam (ng/mL)	261,6±63,5	261,6±82,3	0,897
ICAM at 24 hours post PPCI (ng/mL)	248,5±55,7	287,7±122,0	0,078
Delta ICAM	**-13,0±38,5**	**26,1±67,0**	**0,003**

METHODS This is a randomized, double-blinded, controlled trial. Evaluations were performed on 76 STEMI patients who underwent PPCI at National Cardiac Center Harapan Kita (NCCHK) from February 2014 to August 2014. Patients were randomly classified into two groups (Atorvastatin 80 mg and Placebo).Laboratory data on ICAM were taken twice (0-hour and 24-hour post PPCI) and examined at Prodia's Laboratorium. Statistical analyses using SPSS were performed to evaluate the effect of Atorvastatin treatment, which was measured by delta ICAM.

RESULTS There were no difference between two groups (Atorvastatin vs. Placebo) in terms of clinical, supporting data, and angiographic findings. Delta ICAM values showed significant difference between two groups, which are Atorvastatin 80 mg (-13.0±38.5 ng/mL) and Placebo (26.1±67.0 ng/mL, p 0.003). Linear regression analysis (adjusted analysis; according to age, sex, diabetes, and renal insufficiency) showed coefficient of -31.17 ng/mL with p 0.037.

CONCLUSION This study showed that acute Atorvastatin 80 mg treatment pre-PPCI reduces endothelial inflammatory response which was measured by ICAM.
Keywords: STEMI, PPCI, inflammation, Atorvastatin, ICAM

PERIPHERAL VASCULAR INTERVENTION (NON-CAROTID, NON-NEUROVASCULAR) (TCTAP A-097 TO TCTAP A-106)

TCTAP A-097

Tips and Outcomes of Coil Embolization for Type II Endoleak After Ever

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BACKGROUND Aneurysm expansion due to type 2 endoleak is one of the major troubles after endovascular aneurysm repair (EVAR). Long-term outcome about persistent type 2 endoleak is still unclear. The aim of this study is to evaluate the clinical significance of persistent type II Endoleak and feasibility of additional coil embolization in patients with abdominal aortic aneurysm (AAA) after EVAR.

METHODS We retrospectively analyzed consecutive 236 patients underwent EVAR for abdominal aortic aneurysm in Kyoto university hospital, between March 2003 and June 2014.

RESULTS Mean age was 75.9±7.6 years old and 194 cases (82%) was male. Mean follow up period was 1021±687 days. Persistent type II endoleak was observed in 28 cases (11.9%). Fifteen cases were Excluder, 11cases were Zenith and 2 cases was Power link. Aneurysm expansion than 5mm was more often observed in patient with type II endoleak (25% vs. 2%). We performed Coil embolization for 14 cases due to aneurysm expansion larger than 5mm. One case need surgical conversion due to aneurysm expansion and failed coil embolization. After coil embolization, aneurysm expansion was stopped or decreased in 12 cases (85%).

TCTAP A-098

The Clinical Outcomes of EVT for Restenosis of Superficial Femoral Artery Stent with Jailed Deep Femoral Artery

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BACKGROUND The clinical outcomes of EVT for the restenosis of SFA stent with jailed DFA were poorly understood. The aim of this study was to reveal the SFA patency and the fate of DFA after EVT for the restenosis of SFA stent with jailed DFA.

METHODS From April 2007 to January 2013, we performed de novo 490 ostial SFA stenting with jailed DFA. Of these, restenosis had occurred in the 32 lesions of 19 patients. We performed ballooning or stenting for the SFA restenosis and compared the clinical outcomes at 1, 6, and 12 month.

RESULTS There were no significant differences in the patient background and characteristics between the two groups. Overall primary patency was 96.7%, 87.1% and 58.3%, assisted primary patency was 100%, 90.3% and 80.0%,freedom from MALE was 96.9%, 90.3%,and 83.3%, and DFA patency was 96.7%,93.3%,and 93.1% at 1, 6 and 12 month. Primary patency at 12month tend to be lower in the ballooning (47.1% versus 85.7%, p=0.06) and assisted primary patency at 12 month was significantly lower in ballooning than

stenting. (73%versus 100%, p=0.05) However, there was no significant difference in freedom from MALE and DFA patency. (N.S.)

CONCLUSION The results of stenting for in stent restenosis of SFA with jailed DFA were favorable than ballooning and the 12 month fate of DFA was acceptable in this study.

TCTAP A-099

Unique Endoprosthesis Designed to Treat Aorto-Iliac Aneurysms: A Single Centre Early Experience

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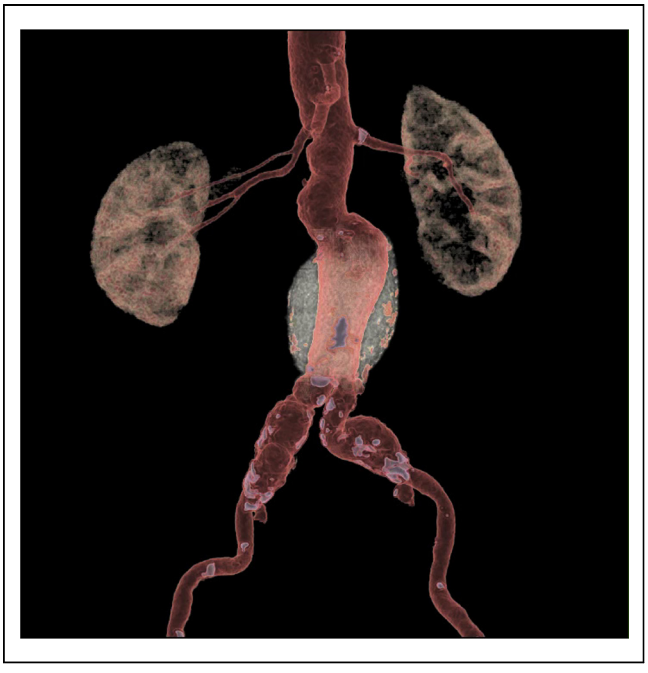
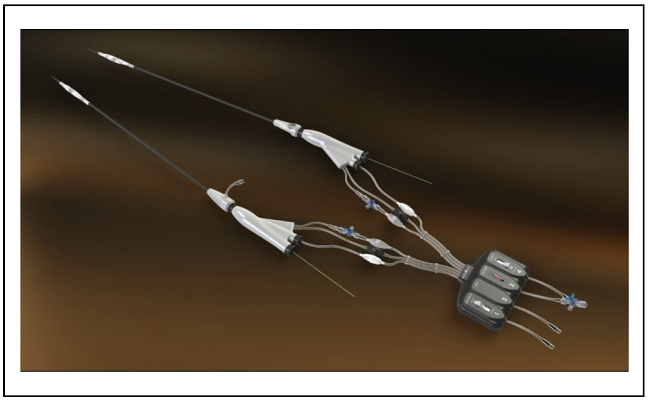
BACKGROUND Ectatic and aneurysmal iliac arteries adversely affect the treatment and long-term results of EVAR. Objective of the study is to evaluate the use of novel technology to treat complex aortic aneurysms involving iliac arteries. We reviewed our first experience with an unique endoprosthesis which is designed to treat aneurysms by filling the aneurysm sac with a quick-setting polymer. Polymer is contained in endobag surrounding the endoprothesis. The filled endobags obliterate the aneurysm sac while providing support and stability to the flow lumens. With the new technology aneurysmal iliac arteries are treated keeping internal iliac arteries patent.





METHODS Patients with aorto-iliac aneurysms treated in our center using the Nellix (Endologix, Inc.) endograft were reviewed. Patients were treated in catheterization laboratory under regional or general anaesthesia using femoral artery approach. Analyses were conducted in accordance with the endovascular aneurysm reporting standards. Follow-up studies accrued at discharge, one, 6, and 12 months, and included computed tomography angiography and duplex ultrasound angiography scans, and flat plate radiography.